



## 101ST GENERAL ASSEMBLY

### State of Illinois

2019 and 2020

SB3297

Introduced 2/11/2020, by Sen. Laura Fine

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act. In provisions concerning income verification to determine if an applicant is eligible for the benefits provided under those Acts, provides that a month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. Amends the Illinois Public Aid Code. Removes a provision that set rates or payments for home health visits at \$72 for dates of service in and after July 1, 2014. Removes a provision that set rates or payments for the certified nursing assistant component of the home health agency rate at \$20 for dates of service on and after July 1, 2014. Requires the Department of Healthcare and Family Services to adopt, by rule, a model similar to the psychiatric Collaborative Care Model required under the Illinois Insurance Code. In a provision concerning assessments for long-term care facilities, provides that the Department of Healthcare and Family Services shall provide a self-reporting notice of the assessment form that a long-term care facility completes for the required period and submits with its assessment payment to the Department. In a provision concerning income verification to determine if an applicant is eligible for the medical assistance benefits provided under the Code, provides that a month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. Repeals a provision requiring the Department to conduct an annual audit of the County Provider Trust Fund. Amends the Illinois Health Information Exchange and Technology Act and the Regulatory Sunset Act. Provides that the Illinois Health Information Exchange and Technology Act is repealed on January 1, 2026 (rather than January 1, 2021). Effective immediately.

LRB101 18060 KTG 70135 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**  
3 **represented in the General Assembly:**

4 Section 1. The Regulatory Sunset Act is amended by changing  
5 Sections 4.31 and 4.36 as follows:

6 (5 ILCS 80/4.31)

7 Sec. 4.31. Acts repealed on January 1, 2021. The following  
8 Acts are repealed on January 1, 2021:

9 The Crematory Regulation Act.

10 The Cemetery Oversight Act.

11 ~~The Illinois Health Information Exchange and Technology~~  
12 ~~Act.~~

13 The Radiation Protection Act of 1990.

14 (Source: P.A. 96-1041, eff. 7-14-10; 96-1331, eff. 7-27-10;  
15 incorporates P.A. 96-863, eff. 3-1-10; 97-333, eff. 8-12-11.)

16 (5 ILCS 80/4.36)

17 Sec. 4.36. Acts repealed on January 1, 2026. The following  
18 Acts are repealed on January 1, 2026:

19 The Barber, Cosmetology, Esthetics, Hair Braiding, and  
20 Nail Technology Act of 1985.

21 The Collection Agency Act.

22 The Hearing Instrument Consumer Protection Act.

1 The Illinois Athletic Trainers Practice Act.

2 The Illinois Dental Practice Act.

3 The Illinois Health Information Exchange and Technology  
4 Act.

5 The Illinois Roofing Industry Licensing Act.

6 The Illinois Physical Therapy Act.

7 The Professional Geologist Licensing Act.

8 The Respiratory Care Practice Act.

9 (Source: P.A. 99-26, eff. 7-10-15; 99-204, eff. 7-30-15;  
10 99-227, eff. 8-3-15; 99-229, eff. 8-3-15; 99-230, eff. 8-3-15;  
11 99-427, eff. 8-21-15; 99-469, eff. 8-26-15; 99-492, eff.  
12 12-31-15; 99-642, eff. 7-28-16.)

13 Section 5. Amends the Illinois Health Information Exchange  
14 and Technology Act is amended by adding Section 996 as follows:

15 (20 ILCS 3860/996 new)

16 Sec. 996. Repeal. This Act is repealed as provided in the  
17 Regulatory Sunset Act.

18 Section 10. The Children's Health Insurance Program Act is  
19 amended by changing Section 7 as follows:

20 (215 ILCS 106/7)

21 Sec. 7. Eligibility verification. Notwithstanding any  
22 other provision of this Act, with respect to applications for

1 benefits provided under the Program, eligibility shall be  
2 determined in a manner that ensures program integrity and that  
3 complies with federal law and regulations while minimizing  
4 unnecessary barriers to enrollment. To this end, as soon as  
5 practicable, and unless the Department receives written denial  
6 from the federal government, this Section shall be implemented:

7 (a) The Department of Healthcare and Family Services or its  
8 designees shall:

9 (1) By no later than July 1, 2011, require verification  
10 of, at a minimum, one month's income from all sources  
11 required for determining the eligibility of applicants to  
12 the Program. Such verification shall take the form of pay  
13 stubs, business or income and expense records for  
14 self-employed persons, letters from employers, and any  
15 other valid documentation of income including data  
16 obtained electronically by the Department or its designees  
17 from other sources as described in subsection (b) of this  
18 Section. A month's income may be verified by a single pay  
19 stub with the monthly income extrapolated from the time  
20 period covered by the pay stub.

21 (2) By no later than October 1, 2011, require  
22 verification of, at a minimum, one month's income from all  
23 sources required for determining the continued eligibility  
24 of recipients at their annual review of eligibility under  
25 the Program. Such verification shall take the form of pay  
26 stubs, business or income and expense records for

1 self-employed persons, letters from employers, and any  
2 other valid documentation of income including data  
3 obtained electronically by the Department or its designees  
4 from other sources as described in subsection (b) of this  
5 Section. A month's income may be verified by a single pay  
6 stub with the monthly income extrapolated from the time  
7 period covered by the pay stub. The Department shall send a  
8 notice to the recipient at least 60 days prior to the end  
9 of the period of eligibility that informs them of the  
10 requirements for continued eligibility. Information the  
11 Department receives prior to the annual review, including  
12 information available to the Department as a result of the  
13 recipient's application for other non-health care  
14 benefits, that is sufficient to make a determination of  
15 continued eligibility for medical assistance or for  
16 benefits provided under the Program may be reviewed and  
17 verified, and subsequent action taken including client  
18 notification of continued eligibility for medical  
19 assistance or for benefits provided under the Program. The  
20 date of client notification establishes the date for  
21 subsequent annual eligibility reviews. If a recipient does  
22 not fulfill the requirements for continued eligibility by  
23 the deadline established in the notice, a notice of  
24 cancellation shall be issued to the recipient and coverage  
25 shall end no later than the last day of the month following  
26 the last day of the eligibility period. A recipient's

1 eligibility may be reinstated without requiring a new  
2 application if the recipient fulfills the requirements for  
3 continued eligibility prior to the end of the third month  
4 following the last date of coverage (or longer period if  
5 required by federal regulations). Nothing in this Section  
6 shall prevent an individual whose coverage has been  
7 cancelled from reapplying for health benefits at any time.

8 (3) By no later than July 1, 2011, require verification  
9 of Illinois residency.

10 (b) The Department shall establish or continue cooperative  
11 arrangements with the Social Security Administration, the  
12 Illinois Secretary of State, the Department of Human Services,  
13 the Department of Revenue, the Department of Employment  
14 Security, and any other appropriate entity to gain electronic  
15 access, to the extent allowed by law, to information available  
16 to those entities that may be appropriate for electronically  
17 verifying any factor of eligibility for benefits under the  
18 Program. Data relevant to eligibility shall be provided for no  
19 other purpose than to verify the eligibility of new applicants  
20 or current recipients of health benefits under the Program.  
21 Data will be requested or provided for any new applicant or  
22 current recipient only insofar as that individual's  
23 circumstances are relevant to that individual's or another  
24 individual's eligibility.

25 (c) Within 90 days of the effective date of this amendatory  
26 Act of the 96th General Assembly, the Department of Healthcare

1 and Family Services shall send notice to current recipients  
2 informing them of the changes regarding their eligibility  
3 verification.

4 (Source: P.A. 101-209, eff. 8-5-19.)

5 Section 15. The Covering ALL KIDS Health Insurance Act is  
6 amended by changing Section 7 as follows:

7 (215 ILCS 170/7)

8 (Section scheduled to be repealed on October 1, 2024)

9 Sec. 7. Eligibility verification. Notwithstanding any  
10 other provision of this Act, with respect to applications for  
11 benefits provided under the Program, eligibility shall be  
12 determined in a manner that ensures program integrity and that  
13 complies with federal law and regulations while minimizing  
14 unnecessary barriers to enrollment. To this end, as soon as  
15 practicable, and unless the Department receives written denial  
16 from the federal government, this Section shall be implemented:

17 (a) The Department of Healthcare and Family Services or its  
18 designees shall:

19 (1) By July 1, 2011, require verification of, at a  
20 minimum, one month's income from all sources required for  
21 determining the eligibility of applicants to the Program.  
22 Such verification shall take the form of pay stubs,  
23 business or income and expense records for self-employed  
24 persons, letters from employers, and any other valid

1 documentation of income including data obtained  
2 electronically by the Department or its designees from  
3 other sources as described in subsection (b) of this  
4 Section. A month's income may be verified by a single pay  
5 stub with the monthly income extrapolated from the time  
6 period covered by the pay stub.

7 (2) By October 1, 2011, require verification of, at a  
8 minimum, one month's income from all sources required for  
9 determining the continued eligibility of recipients at  
10 their annual review of eligibility under the Program. Such  
11 verification shall take the form of pay stubs, business or  
12 income and expense records for self-employed persons,  
13 letters from employers, and any other valid documentation  
14 of income including data obtained electronically by the  
15 Department or its designees from other sources as described  
16 in subsection (b) of this Section. A month's income may be  
17 verified by a single pay stub with the monthly income  
18 extrapolated from the time period covered by the pay stub.  
19 The Department shall send a notice to recipients at least  
20 60 days prior to the end of their period of eligibility  
21 that informs them of the requirements for continued  
22 eligibility. Information the Department receives prior to  
23 the annual review, including information available to the  
24 Department as a result of the recipient's application for  
25 other non-health care benefits, that is sufficient to make  
26 a determination of continued eligibility for benefits

1 provided under this Act, the Children's Health Insurance  
2 Program Act, or Article V of the Illinois Public Aid Code  
3 may be reviewed and verified, and subsequent action taken  
4 including client notification of continued eligibility for  
5 benefits provided under this Act, the Children's Health  
6 Insurance Program Act, or Article V of the Illinois Public  
7 Aid Code. The date of client notification establishes the  
8 date for subsequent annual eligibility reviews. If a  
9 recipient does not fulfill the requirements for continued  
10 eligibility by the deadline established in the notice, a  
11 notice of cancellation shall be issued to the recipient and  
12 coverage shall end no later than the last day of the month  
13 following the last day of the eligibility period. A  
14 recipient's eligibility may be reinstated without  
15 requiring a new application if the recipient fulfills the  
16 requirements for continued eligibility prior to the end of  
17 the third month following the last date of coverage (or  
18 longer period if required by federal regulations). Nothing  
19 in this Section shall prevent an individual whose coverage  
20 has been cancelled from reapplying for health benefits at  
21 any time.

22 (3) By July 1, 2011, require verification of Illinois  
23 residency.

24 (b) The Department shall establish or continue cooperative  
25 arrangements with the Social Security Administration, the  
26 Illinois Secretary of State, the Department of Human Services,

1 the Department of Revenue, the Department of Employment  
2 Security, and any other appropriate entity to gain electronic  
3 access, to the extent allowed by law, to information available  
4 to those entities that may be appropriate for electronically  
5 verifying any factor of eligibility for benefits under the  
6 Program. Data relevant to eligibility shall be provided for no  
7 other purpose than to verify the eligibility of new applicants  
8 or current recipients of health benefits under the Program.  
9 Data will be requested or provided for any new applicant or  
10 current recipient only insofar as that individual's  
11 circumstances are relevant to that individual's or another  
12 individual's eligibility.

13 (c) Within 90 days of the effective date of this amendatory  
14 Act of the 96th General Assembly, the Department of Healthcare  
15 and Family Services shall send notice to current recipients  
16 informing them of the changes regarding their eligibility  
17 verification.

18 (Source: P.A. 101-209, eff. 8-5-19.)

19 Section 20. The Illinois Public Aid Code is amended by  
20 changing Sections 5-5e, 5-16.8, 5B-4, and 11-5.1 as follows:

21 (305 ILCS 5/5-5e)

22 Sec. 5-5e. Adjusted rates of reimbursement.

23 (a) Rates or payments for services in effect on June 30,  
24 2012 shall be adjusted and services shall be affected as

1 required by any other provision of Public Act 97-689. In  
2 addition, the Department shall do the following:

3 (1) Delink the per diem rate paid for supportive living  
4 facility services from the per diem rate paid for nursing  
5 facility services, effective for services provided on or  
6 after May 1, 2011 and before July 1, 2019.

7 (2) Cease payment for bed reserves in nursing  
8 facilities and specialized mental health rehabilitation  
9 facilities; for purposes of therapeutic home visits for  
10 individuals scoring as TBI on the MDS 3.0, beginning June  
11 1, 2015, the Department shall approve payments for bed  
12 reserves in nursing facilities and specialized mental  
13 health rehabilitation facilities that have at least a 90%  
14 occupancy level and at least 80% of their residents are  
15 Medicaid eligible. Payment shall be at a daily rate of 75%  
16 of an individual's current Medicaid per diem and shall not  
17 exceed 10 days in a calendar month.

18 (2.5) Cease payment for bed reserves for purposes of  
19 inpatient hospitalizations to intermediate care facilities  
20 for persons with developmental ~~development~~ disabilities,  
21 except in the instance of residents who are under 21 years  
22 of age.

23 (3) Cease payment of the \$10 per day add-on payment to  
24 nursing facilities for certain residents with  
25 developmental disabilities.

26 (b) After the application of subsection (a),

1 notwithstanding any other provision of this Code to the  
2 contrary and to the extent permitted by federal law, on and  
3 after July 1, 2012, the rates of reimbursement for services and  
4 other payments provided under this Code shall further be  
5 reduced as follows:

6 (1) Rates or payments for physician services, dental  
7 services, or community health center services reimbursed  
8 through an encounter rate, and services provided under the  
9 Medicaid Rehabilitation Option of the Illinois Title XIX  
10 State Plan shall not be further reduced, except as provided  
11 in Section 5-5b.1.

12 (2) Rates or payments, or the portion thereof, paid to  
13 a provider that is operated by a unit of local government  
14 or State University that provides the non-federal share of  
15 such services shall not be further reduced, except as  
16 provided in Section 5-5b.1.

17 (3) Rates or payments for hospital services delivered  
18 by a hospital defined as a Safety-Net Hospital under  
19 Section 5-5e.1 of this Code shall not be further reduced,  
20 except as provided in Section 5-5b.1.

21 (4) Rates or payments for hospital services delivered  
22 by a Critical Access Hospital, which is an Illinois  
23 hospital designated as a critical care hospital by the  
24 Department of Public Health in accordance with 42 CFR 485,  
25 Subpart F, shall not be further reduced, except as provided  
26 in Section 5-5b.1.

1           (5) Rates or payments for Nursing Facility Services  
2 shall only be further adjusted pursuant to Section 5-5.2 of  
3 this Code.

4           (6) Rates or payments for services delivered by long  
5 term care facilities licensed under the ID/DD Community  
6 Care Act or the MC/DD Act and developmental training  
7 services shall not be further reduced.

8           (7) Rates or payments for services provided under  
9 capitation rates shall be adjusted taking into  
10 consideration the rates reduction and covered services  
11 required by Public Act 97-689.

12           (8) For hospitals not previously described in this  
13 subsection, the rates or payments for hospital services  
14 shall be further reduced by 3.5%, except for payments  
15 authorized under Section 5A-12.4 of this Code.

16           (9) For all other rates or payments for services  
17 delivered by providers not specifically referenced in  
18 paragraphs (1) through (8), rates or payments shall be  
19 further reduced by 2.7%.

20           (c) Any assessment imposed by this Code shall continue and  
21 nothing in this Section shall be construed to cause it to  
22 cease.

23           (d) Notwithstanding any other provision of this Code to the  
24 contrary, subject to federal approval under Title XIX of the  
25 Social Security Act, for dates of service on and after July 1,  
26 2014, rates or payments for services provided for the purpose

1 of transitioning children from a hospital to home placement or  
2 other appropriate setting by a children's community-based  
3 health care center authorized under the Alternative Health Care  
4 Delivery Act shall be \$683 per day.

5 (e) (Blank) ~~Notwithstanding any other provision of this~~  
6 ~~Code to the contrary, subject to federal approval under Title~~  
7 ~~XIX of the Social Security Act, for dates of service on and~~  
8 ~~after July 1, 2014, rates or payments for home health visits~~  
9 ~~shall be \$72.~~

10 (f) (Blank) ~~Notwithstanding any other provision of this~~  
11 ~~Code to the contrary, subject to federal approval under Title~~  
12 ~~XIX of the Social Security Act, for dates of service on and~~  
13 ~~after July 1, 2014, rates or payments for the certified nursing~~  
14 ~~assistant component of the home health agency rate shall be~~  
15 ~~\$20.~~

16 (Source: P.A. 101-10, eff. 6-5-19; revised 9-12-19.)

17 (305 ILCS 5/5-16.8)

18 Sec. 5-16.8. Required health benefits. The medical  
19 assistance program shall (i) provide the post-mastectomy care  
20 benefits required to be covered by a policy of accident and  
21 health insurance under Section 356t and the coverage required  
22 under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.26,  
23 356z.29, ~~and~~ 356z.32, ~~and~~ 356z.33, 356z.34, and 356z.35 of the  
24 Illinois Insurance Code and (ii) be subject to the provisions  
25 of Sections 356z.19, 364.01, 370c, and 370c.1 of the Illinois

1 Insurance Code.

2 The Department, by rule, shall adopt a model similar to the  
3 requirements of Section 356z.39 of the Illinois Insurance Code.

4 On and after July 1, 2012, the Department shall reduce any  
5 rate of reimbursement for services or other payments or alter  
6 any methodologies authorized by this Code to reduce any rate of  
7 reimbursement for services or other payments in accordance with  
8 Section 5-5e.

9 To ensure full access to the benefits set forth in this  
10 Section, on and after January 1, 2016, the Department shall  
11 ensure that provider and hospital reimbursement for  
12 post-mastectomy care benefits required under this Section are  
13 no lower than the Medicare reimbursement rate.

14 (Source: P.A. 100-138, eff. 8-18-17; 100-863, eff. 8-14-18;  
15 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff.  
16 7-12-19; 101-218, eff. 1-1-20; 101-281, eff. 1-1-20; 101-371,  
17 eff. 1-1-20; 101-574, eff. 1-1-20; revised 10-16-19.)

18 (305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

19 Sec. 5B-4. Payment of assessment; penalty.

20 (a) The assessment imposed by Section 5B-2 shall be due and  
21 payable monthly, on the last State business day of the month  
22 for occupied bed days reported for the preceding third month  
23 prior to the month in which the tax is payable and due. A  
24 facility that has delayed payment due to the State's failure to  
25 reimburse for services rendered may request an extension on the

1 due date for payment pursuant to subsection (b) and shall pay  
2 the assessment within 30 days of reimbursement by the  
3 Department. The Illinois Department may provide that county  
4 nursing homes directed and maintained pursuant to Section  
5 5-1005 of the Counties Code may meet their assessment  
6 obligation by certifying to the Illinois Department that county  
7 expenditures have been obligated for the operation of the  
8 county nursing home in an amount at least equal to the amount  
9 of the assessment.

10 (a-5) The Illinois Department shall provide for an  
11 electronic submission process for each long-term care facility  
12 to report at a minimum the number of occupied bed days of the  
13 long-term care facility for the reporting period and other  
14 reasonable information the Illinois Department requires for  
15 the administration of its responsibilities under this Code.  
16 Beginning July 1, 2013, a separate electronic submission shall  
17 be completed for each long-term care facility in this State  
18 operated by a long-term care provider. The Illinois Department  
19 shall provide a self-reporting notice of the assessment form  
20 that the long-term care facility completes for the required  
21 period and submits with its assessment payment to the Illinois  
22 Department. ~~shall prepare an assessment bill stating the amount~~  
23 ~~due and payable each month and submit it to each long term care~~  
24 ~~facility via an electronic process. Each assessment payment~~  
25 ~~shall be accompanied by a copy of the assessment bill sent to~~  
26 ~~the long term care facility by the Illinois Department.~~ To the

1 extent practicable, the Department shall coordinate the  
2 assessment reporting requirements with other reporting  
3 required of long-term care facilities.

4 (b) The Illinois Department is authorized to establish  
5 delayed payment schedules for long-term care providers that are  
6 unable to make assessment payments when due under this Section  
7 due to financial difficulties, as determined by the Illinois  
8 Department. The Illinois Department may not deny a request for  
9 delay of payment of the assessment imposed under this Article  
10 if the long-term care provider has not been paid for services  
11 provided during the month on which the assessment is levied or  
12 the Medicaid managed care organization has not been paid by the  
13 State.

14 (c) If a long-term care provider fails to pay the full  
15 amount of an assessment payment when due (including any  
16 extensions granted under subsection (b)), there shall, unless  
17 waived by the Illinois Department for reasonable cause, be  
18 added to the assessment imposed by Section 5B-2 a penalty  
19 assessment equal to the lesser of (i) 5% of the amount of the  
20 assessment payment not paid on or before the due date plus 5%  
21 of the portion thereof remaining unpaid on the last day of each  
22 month thereafter or (ii) 100% of the assessment payment amount  
23 not paid on or before the due date. For purposes of this  
24 subsection, payments will be credited first to unpaid  
25 assessment payment amounts (rather than to penalty or  
26 interest), beginning with the most delinquent assessment

1 payments. Payment cycles of longer than 60 days shall be one  
2 factor the Director takes into account in granting a waiver  
3 under this Section.

4 (c-5) If a long-term care facility fails to file its  
5 assessment bill with payment, there shall, unless waived by the  
6 Illinois Department for reasonable cause, be added to the  
7 assessment due a penalty assessment equal to 25% of the  
8 assessment due. After July 1, 2013, no penalty shall be  
9 assessed under this Section if the Illinois Department does not  
10 provide a process for the electronic submission of the  
11 information required by subsection (a-5).

12 (d) Nothing in this amendatory Act of 1993 shall be  
13 construed to prevent the Illinois Department from collecting  
14 all amounts due under this Article pursuant to an assessment  
15 imposed before the effective date of this amendatory Act of  
16 1993.

17 (e) Nothing in this amendatory Act of the 96th General  
18 Assembly shall be construed to prevent the Illinois Department  
19 from collecting all amounts due under this Code pursuant to an  
20 assessment, tax, fee, or penalty imposed before the effective  
21 date of this amendatory Act of the 96th General Assembly.

22 (f) No installment of the assessment imposed by Section  
23 5B-2 shall be due and payable until after the Department  
24 notifies the long-term care providers, in writing, that the  
25 payment methodologies to long-term care providers required  
26 under Section 5-5.4 of this Code have been approved by the

1 Centers for Medicare and Medicaid Services of the U.S.  
2 Department of Health and Human Services and the waivers under  
3 42 CFR 433.68 for the assessment imposed by this Section, if  
4 necessary, have been granted by the Centers for Medicare and  
5 Medicaid Services of the U.S. Department of Health and Human  
6 Services. Upon notification to the Department of approval of  
7 the payment methodologies required under Section 5-5.4 of this  
8 Code and the waivers granted under 42 CFR 433.68, all  
9 installments otherwise due under Section 5B-4 prior to the date  
10 of notification shall be due and payable to the Department upon  
11 written direction from the Department within 90 days after  
12 issuance by the Comptroller of the payments required under  
13 Section 5-5.4 of this Code.

14 (Source: P.A. 100-501, eff. 6-1-18.)

15 (305 ILCS 5/11-5.1)

16 Sec. 11-5.1. Eligibility verification. Notwithstanding any  
17 other provision of this Code, with respect to applications for  
18 medical assistance provided under Article V of this Code,  
19 eligibility shall be determined in a manner that ensures  
20 program integrity and complies with federal laws and  
21 regulations while minimizing unnecessary barriers to  
22 enrollment. To this end, as soon as practicable, and unless the  
23 Department receives written denial from the federal  
24 government, this Section shall be implemented:

25 (a) The Department of Healthcare and Family Services or its

1 designees shall:

2 (1) By no later than July 1, 2011, require verification  
3 of, at a minimum, one month's income from all sources  
4 required for determining the eligibility of applicants for  
5 medical assistance under this Code. Such verification  
6 shall take the form of pay stubs, business or income and  
7 expense records for self-employed persons, letters from  
8 employers, and any other valid documentation of income  
9 including data obtained electronically by the Department  
10 or its designees from other sources as described in  
11 subsection (b) of this Section. A month's income may be  
12 verified by a single pay stub with the monthly income  
13 extrapolated from the time period covered by the pay stub.

14 (2) By no later than October 1, 2011, require  
15 verification of, at a minimum, one month's income from all  
16 sources required for determining the continued eligibility  
17 of recipients at their annual review of eligibility for  
18 medical assistance under this Code. Information the  
19 Department receives prior to the annual review, including  
20 information available to the Department as a result of the  
21 recipient's application for other non-Medicaid benefits,  
22 that is sufficient to make a determination of continued  
23 Medicaid eligibility may be reviewed and verified, and  
24 subsequent action taken including client notification of  
25 continued Medicaid eligibility. The date of client  
26 notification establishes the date for subsequent annual

1 Medicaid eligibility reviews. Such verification shall take  
2 the form of pay stubs, business or income and expense  
3 records for self-employed persons, letters from employers,  
4 and any other valid documentation of income including data  
5 obtained electronically by the Department or its designees  
6 from other sources as described in subsection (b) of this  
7 Section. A month's income may be verified by a single pay  
8 stub with the monthly income extrapolated from the time  
9 period covered by the pay stub. The Department shall send a  
10 notice to recipients at least 60 days prior to the end of  
11 their period of eligibility that informs them of the  
12 requirements for continued eligibility. If a recipient  
13 does not fulfill the requirements for continued  
14 eligibility by the deadline established in the notice a  
15 notice of cancellation shall be issued to the recipient and  
16 coverage shall end no later than the last day of the month  
17 following the last day of the eligibility period. A  
18 recipient's eligibility may be reinstated without  
19 requiring a new application if the recipient fulfills the  
20 requirements for continued eligibility prior to the end of  
21 the third month following the last date of coverage (or  
22 longer period if required by federal regulations). Nothing  
23 in this Section shall prevent an individual whose coverage  
24 has been cancelled from reapplying for health benefits at  
25 any time.

26 (3) By no later than July 1, 2011, require verification

1 of Illinois residency.

2 The Department, with federal approval, may choose to adopt  
3 continuous financial eligibility for a full 12 months for  
4 adults on Medicaid.

5 (b) The Department shall establish or continue cooperative  
6 arrangements with the Social Security Administration, the  
7 Illinois Secretary of State, the Department of Human Services,  
8 the Department of Revenue, the Department of Employment  
9 Security, and any other appropriate entity to gain electronic  
10 access, to the extent allowed by law, to information available  
11 to those entities that may be appropriate for electronically  
12 verifying any factor of eligibility for benefits under the  
13 Program. Data relevant to eligibility shall be provided for no  
14 other purpose than to verify the eligibility of new applicants  
15 or current recipients of health benefits under the Program.  
16 Data shall be requested or provided for any new applicant or  
17 current recipient only insofar as that individual's  
18 circumstances are relevant to that individual's or another  
19 individual's eligibility.

20 (c) Within 90 days of the effective date of this amendatory  
21 Act of the 96th General Assembly, the Department of Healthcare  
22 and Family Services shall send notice to current recipients  
23 informing them of the changes regarding their eligibility  
24 verification.

25 (d) As soon as practical if the data is reasonably  
26 available, but no later than January 1, 2017, the Department

1 shall compile on a monthly basis data on eligibility  
2 redeterminations of beneficiaries of medical assistance  
3 provided under Article V of this Code. This data shall be  
4 posted on the Department's website, and data from prior months  
5 shall be retained and available on the Department's website.  
6 The data compiled and reported shall include the following:

7 (1) The total number of redetermination decisions made  
8 in a month and, of that total number, the number of  
9 decisions to continue or change benefits and the number of  
10 decisions to cancel benefits.

11 (2) A breakdown of enrollee language preference for the  
12 total number of redetermination decisions made in a month  
13 and, of that total number, a breakdown of enrollee language  
14 preference for the number of decisions to continue or  
15 change benefits, and a breakdown of enrollee language  
16 preference for the number of decisions to cancel benefits.  
17 The language breakdown shall include, at a minimum,  
18 English, Spanish, and the next 4 most commonly used  
19 languages.

20 (3) The percentage of cancellation decisions made in a  
21 month due to each of the following:

22 (A) The beneficiary's ineligibility due to excess  
23 income.

24 (B) The beneficiary's ineligibility due to not  
25 being an Illinois resident.

26 (C) The beneficiary's ineligibility due to being

1           deceased.

2           (D) The beneficiary's request to cancel benefits.

3           (E) The beneficiary's lack of response after  
4 notices mailed to the beneficiary are returned to the  
5 Department as undeliverable by the United States  
6 Postal Service.

7           (F) The beneficiary's lack of response to a request  
8 for additional information when reliable information  
9 in the beneficiary's account, or other more current  
10 information, is unavailable to the Department to make a  
11 decision on whether to continue benefits.

12           (G) Other reasons tracked by the Department for the  
13 purpose of ensuring program integrity.

14           (4) If a vendor is utilized to provide services in  
15 support of the Department's redetermination decision  
16 process, the total number of redetermination decisions  
17 made in a month and, of that total number, the number of  
18 decisions to continue or change benefits, and the number of  
19 decisions to cancel benefits (i) with the involvement of  
20 the vendor and (ii) without the involvement of the vendor.

21           (5) Of the total number of benefit cancellations in a  
22 month, the number of beneficiaries who return from  
23 cancellation within one month, the number of beneficiaries  
24 who return from cancellation within 2 months, and the  
25 number of beneficiaries who return from cancellation  
26 within 3 months. Of the number of beneficiaries who return

1 from cancellation within 3 months, the percentage of those  
2 cancellations due to each of the reasons listed under  
3 paragraph (3) of this subsection.

4 (e) The Department shall conduct a complete review of the  
5 Medicaid redetermination process in order to identify changes  
6 that can increase the use of ex parte redetermination  
7 processing. This review shall be completed within 90 days after  
8 the effective date of this amendatory Act of the 101st General  
9 Assembly. Within 90 days of completion of the review, the  
10 Department shall seek written federal approval of policy  
11 changes the review recommended and implement once approved. The  
12 review shall specifically include, but not be limited to, use  
13 of ex parte redeterminations of the following populations:

- 14 (1) Recipients of developmental disabilities services.
- 15 (2) Recipients of benefits under the State's Aid to the  
16 Aged, Blind, or Disabled program.
- 17 (3) Recipients of Medicaid long-term care services and  
18 supports, including waiver services.
- 19 (4) All Modified Adjusted Gross Income (MAGI)  
20 populations.
- 21 (5) Populations with no verifiable income.
- 22 (6) Self-employed people.

23 The report shall also outline populations and  
24 circumstances in which an ex parte redetermination is not a  
25 recommended option.

26 (f) The Department shall explore and implement, as

1 practical and technologically possible, roles that  
2 stakeholders outside State agencies can play to assist in  
3 expediting eligibility determinations and redeterminations  
4 within 24 months after the effective date of this amendatory  
5 Act of the 101st General Assembly. Such practical roles to be  
6 explored to expedite the eligibility determination processes  
7 shall include the implementation of hospital presumptive  
8 eligibility, as authorized by the Patient Protection and  
9 Affordable Care Act.

10 (g) The Department or its designee shall seek federal  
11 approval to enhance the reasonable compatibility standard from  
12 5% to 10%.

13 (h) Reporting. The Department of Healthcare and Family  
14 Services and the Department of Human Services shall publish  
15 quarterly reports on their progress in implementing policies  
16 and practices pursuant to this Section as modified by this  
17 amendatory Act of the 101st General Assembly.

18 (1) The reports shall include, but not be limited to,  
19 the following:

20 (A) Medical application processing, including a  
21 breakdown of the number of MAGI, non-MAGI, long-term  
22 care, and other medical cases pending for various  
23 incremental time frames between 0 to 181 or more days.

24 (B) Medical redeterminations completed, including:

25 (i) a breakdown of the number of households that were  
26 redetermined ex parte and those that were not; (ii) the

1 reasons households were not redetermined ex parte; and  
2 (iii) the relative percentages of these reasons.

3 (C) A narrative discussion on issues identified in  
4 the functioning of the State's Integrated Eligibility  
5 System and progress on addressing those issues, as well  
6 as progress on implementing strategies to address  
7 eligibility backlogs, including expanding ex parte  
8 determinations to ensure timely eligibility  
9 determinations and renewals.

10 (2) Initial reports shall be issued within 90 days  
11 after the effective date of this amendatory Act of the  
12 101st General Assembly.

13 (3) All reports shall be published on the Department's  
14 website.

15 (Source: P.A. 101-209, eff. 8-5-19.)

16 (305 ILCS 5/15-6 rep.)

17 Section 25. The Illinois Public Aid Code is amended by  
18 repealing Section 15-6.

19 Section 99. Effective date. This Act takes effect upon  
20 becoming law.

1 INDEX

2 Statutes amended in order of appearance

3 5 ILCS 80/4.31

4 5 ILCS 80/4.36

5 20 ILCS 3860/996 new

6 215 ILCS 106/7

7 215 ILCS 170/7

8 305 ILCS 5/5-5e

9 305 ILCS 5/5-16.8

10 305 ILCS 5/5B-4 from Ch. 23, par. 5B-4

11 305 ILCS 5/11-5.1

12 305 ILCS 5/15-6 rep.